Adopted December 13, 1997 by the Managed Health Care Improvement Task Force

GOVERNMENT REGULATION AND OVERSIGHT OF MANAGED HEALTH CARE

FINDINGS AND RECOMMENDATIONS

I. THE CURRENT HEALTH CARE MARKET AND CALIFORNIA OVERSIGHT

Health care services are not commodities or like other consumer goods or services. Health care has a special moral status and therefore a particular public interest. Most people consider it unacceptable for others to suffer, to be disabled, or to have shortened lives for lack of access to at least basic medical care. Thus, we have many public programs intended to respond to people's need for care. The markets for health services and health care work imperfectly for many reasons, such as the incentive effects of health insurance that undermine cost-consciousness, the very high cost of information and the asymmetry of knowledge between practitioner and patient, and the wide variations among people in medical risks that make pooling of risks difficult. Health care is often a matter of life and death or disability. Government action is needed to protect public safety. Enabling access to care, assuring quality of care and controlling the cost of care are important public policy problems in part because so much of health care is paid for by taxpayers.

Thus, there are many important roles for government in the financing and regulation of health care and health insurance, including consumer protection; improving the market for health coverage so that competitive incentives keep costs down, quality high, and access to care available; and providing leadership by being a responsible purchaser of health care benefits. One of the roles of government is to protect consumers by creating the conditions for markets to serve consumers well. These conditions include the rule of law (including laws against fraudulent or deceptive practices), securing property rights, defining liability, licensing facilities and professionals, contract enforcement, and anti-trust. The complexity of health insurance contracts makes necessary special rules to ensure there is a meeting of minds between buyers and sellers that lead to the reasonable expectations of reasonable persons being met. Another is maintenance of an acceptable level of quality. Ways the government can improve the market for health coverage include requiring or encouraging the pooling of risks, helping to create an information infrastructure, enabling comparative information, facilitating desirable structural change, considering anti-trust actions, and not creating barriers to market entry. Because of its size and authority, government's role as purchaser is also important.

Nationally, we now spend over a trillion dollars on health care annually, and in California, health care is one of our largest and most dynamic industries. As health care has become a larger proportion of the overall economy, more public and private entrepreneurs have become involved in the industry, developing market innovations that often do not fit neatly into the outdated categories of business and insurance models that have traditionally been regulated. Particularly over the last decade, various forms of managed care companies (health maintenance organizations "HMOs", preferred provider insurance, referred to as preferred provider

Figure 1. Overview of Regulatory Structure

Federal Health Care Regulatory Structure

(Federal HMO Act, Health Care Financing Administration, Department of Labor, etc.)

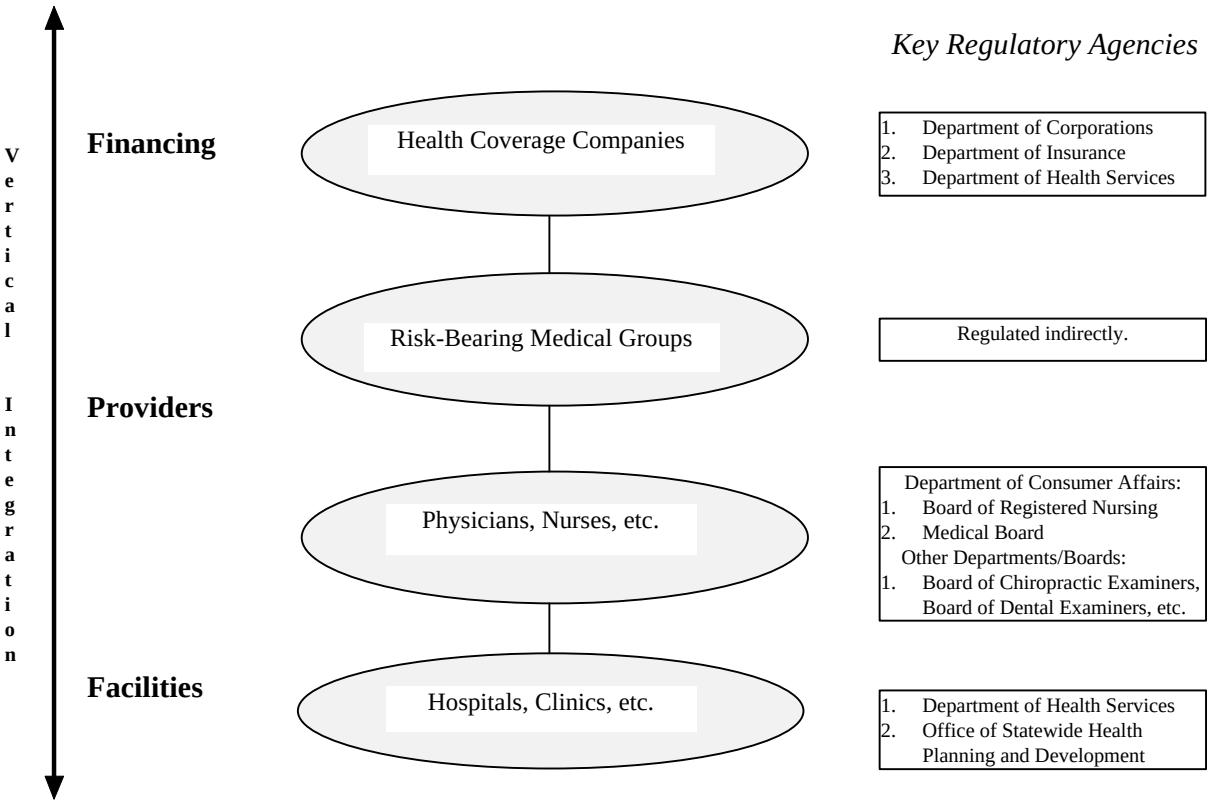
California Health Care Regulatory Structure

Models of Health Care Delivery

HMO **POS** **PPO** **FFS**

Hybrids

DOC DOI



Key Regulatory Agencies

1. Department of Corporations
2. Department of Insurance
3. Department of Health Services

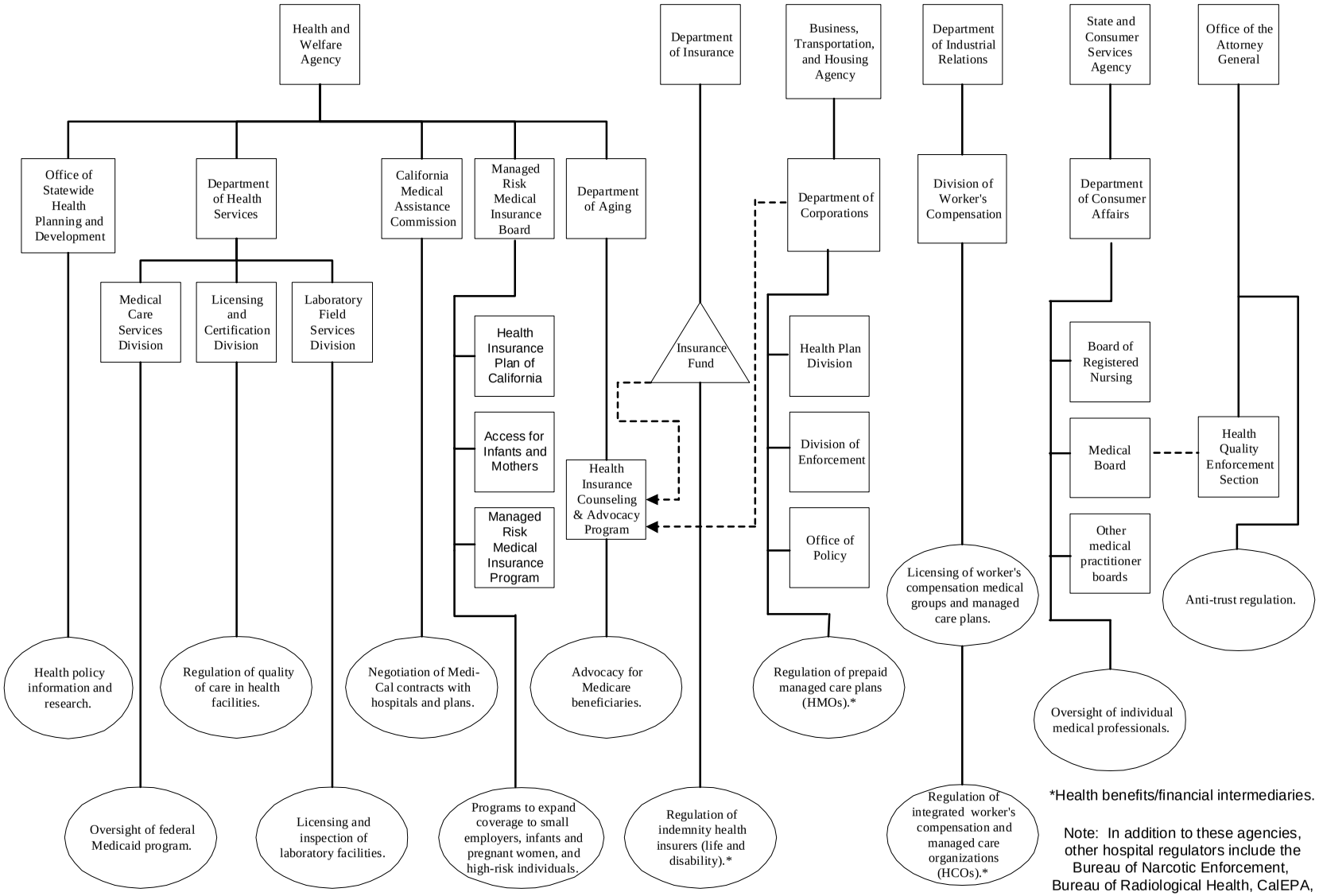
Regulated indirectly.

Department of Consumer Affairs:
1. Board of Registered Nursing
2. Medical Board

Other Departments/Boards:
1. Board of Chiropractic Examiners, Board of Dental Examiners, etc.

1. Department of Health Services
2. Office of Statewide Health Planning and Development

* Other hospital regulators at the state level include the Bureau of Narcotic Enforcement, Bureau of Radiological Health, CalEPA, CalOSHA, Office of Emergency Services, and State Board of Equalization. At the federal level, hospital regulators include the Department of the Treasury, Environmental Protection Agency, Equal Employment Opportunities Commission, Federal Communications Commission, Federal Emergency Management Agency, Food and Drug Administration, and Nuclear Regulatory Commission.



*Health benefits/financial intermediaries.

Note: In addition to these agencies, other hospital regulators include the Bureau of Narcotic Enforcement, Bureau of Radiological Health, CalEPA, CalOSHA, Office of Emergency Services, and State Board of Equalization.

Figure 2. State Health Care Oversight Related to Managed Care

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Figure 3: CALIFORNIA'S MANAGED HEALTH INDUSTRY:
CURRENT STATE REGULATORY OVERSIGHT JURISDICTION

Industry Segment	Financial Intermediaries			Providers			Facilities	
I. REGULATORY FUNCTION	**INDEMNITY INSURANCE**	**PREPAID HEALTH PLANS**	**INDIVIDUAL CLINICIANS Health Aides & Technicians**	**MEDICAL GROUPS**	**HOSPITALS**	**LONG TERM & NURSING FACILITIES**	**SHORT TERM OUTPATIENT CLINICS**
A. Licensure	DOI	DOC	DCA Health Boards DHS Soc. Services	DOC (if bear risk) DIR (workers' comp.) Health Board	DHS	DHS	DHS DCA Health Boards
B. Monitoring/ Auditing	DOI	DOC DHS (Medi-Cal)	-	DOC (if bear risk) DIR (workers' comp.)	DHS	DHS	DHS DCA Health Boards
C. Operational Modifications	DOI	DOC	-	-	DHS	DHS	DHS
D. Complaints	DOI	DOC DHS	DCA Health Boards	DCA Health Boards	DHS	DHS	DHS DCA Health Boards
E. Enforcement	DOI Attorney General	DOC DHS (Medi-Cal)	DCA Health Boards Attorney General	Market (through plans)	DHS	DHS	DHS DCA Health Boards
II. PUBLIC POLICY GOALS							
A. Financial Solvency	DOI	DOC	-	DOC (if bear risk)	DHS CMAC	-	-
B. Quality of Care		DOC DHS (Medi-Cal)	DCA Health Boards	Medical Board (indirectly) Market (through purchasers)	DHS	DHS	DHS
C. Due Process	DOI	DOC DHS (Medi-Cal)	DHS (Medi-Cal)	DHS (Medi-Cal)	DHS	DHS	DHS
D. Access	Market	DOC DHS (Medi-Cal) Market	DHS Market	DHS Market	DHS Market	DHS Market	DHS Market
E. Affordability	Market	DHS (Medi-Cal) Market	Market	Market	Market	Market	Market

KEY

DOC: Department of Corporations.
DOI: Department of Insurance.
DCA Health Boards: Boards under the Department of Consumers Affairs that license and regulate health professionals.
DHS: Department of Health Services
Market: Private Marketplace
DIR: Department of Industrial Relations
CMAC: California Medical Assistance Commission

Many new managed care organizations that are not risk-bearing have virtually no state oversight currently.
Clinics - If business is licensed under the private physician's license, regulation is by Medical Board based primarily on complaints; if licensed by DHS as a clinic, regulation includes periodic audits as well.

organizations "PPOs", point-of-service plans "POS", etc.) have become increasingly involved in managing not only the business elements of health delivery, but the clinical elements as well. As competitors struggle for market position, integration and consolidation among the various entities involved in health care delivery has intensified.[1]

The state of California utilizes a regulatory structure primarily designed in the 1970s, when managed care organizations were responsible for financing the health care of at most a few percent of Californians, to oversee a rapidly evolving industry that has grown many-fold and now covers well over half of all Californians (see Figure 2 and its accompanying matrix of functions, Figure 3). The industry and recent federal law have evolved business forms beyond the definitions that govern existing lines of California government jurisdiction. Consolidation among state regulators could benefit both business, in terms of having a streamlined regulatory structure, and consumers, in terms of having a more sophisticated and accessible oversight organization.

The operations of managed care organizations are controlled by many government and private entities.[2] Health care service plans (i.e., HMOs) are regulated by the Department of Corporations (DOC), the lead agency for health plan regulation, under the Knox-Keene Health Care Service Plan Act of 1975. The DOC administers the Knox-Keene Act primarily by conducting or overseeing health care service plan quality and solvency audits; reviewing, approving or denying health care service plan applications for Knox-Keene licenses, and material modifications and amendments thereto; receiving and resolving consumer complaints; requiring plans to resolve compliance problems; and taking enforcement actions such as cease and desist orders, financial penalties, and court filings. The other predominant form of managed care currently in California is Preferred Provider Insurance (PPI), commonly referred to as Preferred Provider Organizations (PPOs), which when self-funded by employers and managed by third party administrators is not regulated at the state level. The remainder of PPOs are delivered by indemnity insurance companies and regulated under the California Insurance Code, which is enforced by the California Department of Insurance.

The operations of health care service plans and other managed care organizations are also controlled by many other entities, governmental and private. The Department of Health Services (DHS) contracts with some of them to serve Medi-Cal beneficiaries. Its Audits and Investigations Division performs fiscal and medical audits of Medi-Cal managed care organizations. Its Licensing and Certification program licenses the facilities managed care uses. The Department of Industrial Relations (DIR) oversees managed care organizations offering managed care services for work-related injuries and illnesses. The health professionals' boards of California, under the Department of Consumer Affairs (DCA), license health professionals such as doctors, nurses and chiropractors who work for managed care organizations. The Managed Risk Medical Insurance Board (MRMIB) contracts with many managed care organizations involved in Access for Infants and Mothers (AIM) and The Health Insurance Plan of California (HIPC). The single largest customer for many health service plans is the California Public Employees Retirement System (CalPERS) that purchases coverage for 1,000,000 California public employees, retirees and dependents. Health care service plans are also overseen by the Health Care Financing

[1] See Figure 1, which places the California regulatory structure in the context of the currently-consolidating health care marketplace.

[2] The background paper further details the current complex federal and state oversight structures.

Administration (HCFA) for the federal Medicare program to the extent they serve Medicare beneficiaries and by the federal Office of Personnel Management (OPM) that purchases coverage for over nine million federal employees, retirees, and dependents.

These and other government agencies also regulate other health professionals, facilities, and health insurance arrangements. Under the present regulatory structure, however, there is no direct regulation of many medical groups/IPAs as entities by a government agency. Rather, most medical groups/IPAs are regulated indirectly by the Knox-Keene plans with which they contract. In addition, in order for medical groups to accept full capitation contracts, some have received limited licensure from the DOC which require meeting Knox-Keene standards.

The private sector supplements these state and federal regulatory functions through a variety of quality measurement and accreditation organizations that help employers and consumers to evaluate their purchases by providing information. Their efforts, as well as their counterparts that are internal to managed care organizations, are also intended to be used by providers, provider groups and plans to improve quality of care and service. In addition, large purchasers, including government, can use their substantial negotiating power to influence positively the health care system, in particular by providing consumers with the ability to choose the best value plan for their needs, through appropriate information, incentives and choices.

II. IMPROVING THE REGULATORY PROCESS

The Task Force heard and received testimony that there is public dissatisfaction with the current state of managed care regulation. The creation of this Task Force suggests that the Legislature, the Governor, and many citizens believe that there may be some deficiency in the structure or operations of the regulation of the managed care industry. The primary body of law governing the managed care industry in California, the Knox-Keene Act of 1975, has now grown through amendments to two hundred and six pages, and yet it has failed to satisfy the dissatisfied. This certainly calls into question the current regulatory process, regulatory organization, and the most appropriate solution. Attention needs to be focused on the capabilities and limitations of the existing regulatory organization to carry out the intent of existing law in a satisfactory manner, and changes should be implemented to improve the effectiveness of existing regulation.

A. Adequate Attention

The Department of Corporations, housed within the Business, Transportation and Housing Agency, is the primary regulator for business in California. As such, it regulates many kinds of businesses, not just health care service plans. Therefore its leader does not focus 100% of his or her attention on health care service plans or other emerging health care issues. Recently, DOC's leader has been a securities lawyer. This made sense in 1975 when the Knox-Keene Act was passed because health care service plans were few and small, not large enough to warrant their own regulatory entity. Now, more than half of all Californians are enrolled in health care service plans and, as an industry, they are among the largest in the state. Given the size, the complexity, and the high degree of public interest, health care service plans ought to have their own regulatory entity, headed by a person or a board who devotes his or her complete attention to the industry and who has had substantial experience and expertise in health services.

B. Appropriate Leadership

The appropriate leadership of the new state entity for regulation of managed care[3] could be either an appointed individual or an appointed board, with a full-time individual with day-to-day responsibility. The Task Force chose not to make a recommendation on this question, and it was approximately evenly divided on its preference for an individual versus a board. Those that prefer an individual leader argue that the new regulatory authority would not be a legislative body so should not be controlled by a voting board, but rather an individual who could be better held accountable for implementation of the statute. Supporters of a board argue that such a body would provide continuity and stability, a public process and therefore confidence in the decision-making, and greater independence from political interference.

In either case, the ideal leadership of the new state entity for regulation of managed care should have a deep understanding of health care and a well-founded strategic sense of how the industry should evolve, a solid grounding in the health care market. The leadership should have the ability to prioritize law enforcement and to work on a pro-active basis with the industry, employers and consumer groups to define and solve broad system problems. The right person or people must understand medical quality management and how to create conditions that foster quality improvement. The leadership must also understand sympathetically the culture and values of health care. They should be qualified to make judgments as to whether proposed innovations are in the public interest, and if they are, to "fast track" their approval.

C. Compassionate Face

By fulfilling its legal obligation to enforce the law according to the Knox-Keene Act, the DOC often appears insensitive[4]. While compassion might not be something one expects from a government agency, the style of securities law enforcement seems inappropriate when a loved one's life or health is involved. A letter in response to an inquiry that states that no violation of law has been found might be quite appropriate in a matter of securities law, a body of laws and rules that has fairly clear lines and in which the issue is whether or not someone played by the rules. Only money, not lives, is at stake.

For parents, for example, who have lost a child and want to know whether she received the standard of care (a subjective judgment), whether she was cared for by appropriately qualified practitioners, and, if not, what corrective action will be taken, an appropriate response would include (1) reasons why the regulatory authority understands a plan to be or not to be in compliance with the law, (2) reference to contact with a qualified practitioner and the answers he or she provided to their questions, and (3) if their charges were correct, information about the corrective actions taken.

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[3] Throughout this paper, the term "state entity for regulation of managed care" refers to the DOC or its successor. When used in the plural form "state entity(ies)", it refers to DOC and DOI or their successor. The "new state entity" refers specifically to the successor entity recommended in this paper.

[4] While the Task Force did not attempt to discern whether a pattern of insensitivity by the DOC exists, it heard and received testimony from several unhappy citizens who feel they have experienced insensitive treatment.

D. Streamlining Regulation

The regulatory process is needlessly cumbersome and complex. The DOC and other regulators appear to have missed numerous opportunities for streamlining. Cooperation among agencies with private organizations doing similar work could be improved.

A particular example is the regulation of medical groups, IPAs and other entities bearing risk in contracts with Knox-Keene regulated plans. The solvency and the quality of these entities are a matter of legitimate public interest and concern. The average medical group contracts with 15 health plans. The medical groups understandably do not want to share financial information with the health plans with which they are negotiating for payments, and they understandably do not want 15 financial audits per year. Moreover, they understandably feel overburdened by numerous quality audits that disrupt their work and add to their costs. To avoid such redundancy, The Medical Quality Commission and the Pacific Business Group on Health launched an effort to evaluate directly performance of physician groups. The *Physician Value Check Survey* measures clinical quality and member satisfaction. Such private sector "regulation" should be embraced and built upon by the public sector to ensure all groups are included.

E. Developing Capabilities to Meet the Challenges of Accelerating Industry Change

Despite the best efforts of the legislative process, there remains lack of clarity. While the lack of prescription in the Knox-Keene Act allows some flexibility, and the intention of the DOC is to avoid inconsistency and resolve it when found, apparent and actual inconsistencies inevitably exist. In addition, to DOC-regulated health care service plans, some decisions seem inconsistent, subjective, arbitrary, or very different from those that have been imposed on other health care service plans. Plans have also experienced delays when they have submitted material modifications to their filings. Delays are costly to health care service plans and consumers because approval often would enable plans to provide a new product or a product to a new service area.

III. RECOMMENDATIONS

Regulatory organization must consider not only *who* should be the regulator, but also *what* segments of the industry they should regulate, and *how*. The three elements are interdependent and cannot be intelligently treated in isolation. The yardsticks against which any regulatory organization option, including the status quo, must be measured include fairness, capability and expertise, accountability, efficiency, strict enforcement, a systems approach, continuity and stability, adaptability to encourage innovation, and low net fiscal cost.

There are, at present, several pressures on the existing regulatory structure. These include new federal legislation allowing new market forms (e.g., Medical Spending Accounts and Provider Service Organizations); the market development of hybrid models that no longer fit neatly into current regulatory oversight structures; and growing public concerns about quality.

There is, therefore, an unusual opportunity to begin to transition to an integrated and sophisticated oversight structure that can keep up with this rapidly changing, dynamic marketplace. Inherent in the following recommendations is the belief that regulatory authority should ultimately be able to address the contracting, solvency, and other financial aspects of regulation as well as to evaluate

clinical quality of care and medical practice issues and recognize and promote conditions for quality improvement and innovation.

1. Streamline Regulatory Oversight

(a) A new state entity for regulation of managed health care[5] should be created to regulate health care service plans currently regulated by the DOC and to phase-in the regulation of other entities over time, consistent with these recommendations (1.a-f). Appropriate health staff of the DOC will be transferred to the new regulatory entity.

(b) Medical groups and other provider entities that bear significant risk should be directly regulated by the new state entity for solvency and quality. Within a year, the Governor and Legislature should study and recommend to the public as to the method for consolidated, direct regulation by this new entity, of medical groups/IPAs and other provider entities in the state that are not currently directly regulated and who bear significant risk, on the basis of solvency and quality, to the extent they can be shown to be contributing to medical decisions (i.e., not coverage decisions determined contractually by an employer).

(c) Within one year, the Governor and the Legislature should study the feasibility and benefit of consolidating the health care quality review functions of all state governmental agencies within the new entity.

(d) Within two years, the Governor and the Legislature should consider folding into the new state entity the regulation of other health insurers providing insurance through indemnity, PPO and Exclusive Provider Organization (EPO) products currently regulated by DOI.

(e) Subsequently, the merits of folding into the new state entity other regulatory functions (e.g., those that regulate providers, clinicians, and medical facilities) should be examined. However, further consolidation should be phased-in in a manner that minimizes disruption of essential regulatory functions. Any proposed consolidation should weigh the potential benefit and detriment to the public and consider the impact on the stability of the organization.

(f) Any health-related regulatory authority or related government entity not incorporated into this new state entity should develop enhanced electronic capabilities to share information and work together with other oversight entities.

2. Provide Appropriate Leadership

(a) The new oversight organization should be led either:

(1) by a board that would review and approve major policy and regulatory matters, comprised of five or more individuals having specified qualifications, appointed to staggered terms, with a majority appointed by the Governor and at least one member each appointed by the Assembly and the Senate, working with a full-time Chairperson of the Board who has day-to-day operating responsibility and authority and who is an individual

[5] Task Force members suggested through an informal questionnaire that the new entity be named, if led by a board, the "California Managed Care Authority (CMCA)" or, if led by an individual, the "California Office of Health Care Oversight (COHCO)". More appropriate names might include reference to a Board (e.g., the California Managed Care Board) or to a Department (e.g., the California Department of Health Care Oversight) respectively.

of stature in the health services field who can command respect and exercise strategic leadership, appointed by Governor, or

(2) by an individual of stature in the health services field who can command respect and exercise strategic leadership, appointed by the Governor and confirmed by the Senate.

In either case, the leadership of the organization should have a sympathetic understanding of the problems of patients and their families and an understanding of the health care market.

(b) An advisory committee should be established that includes the leaders of other health regulatory agencies as ex-officio/non-voting members, health care experts, and stakeholders.[6]

3. Adopt Appropriate Principles for Regulation

The following principles should guide regulation by the oversight entity: (a) regulation should be as efficient and streamlined as possible, (b) regulation should be conducted in cooperation with other public and private bodies that also regulate or purchase from health care service plans and other health insurers to the maximum extent possible, and (c) regulation should recognize and expedite approval of beneficial innovations (i.e., those that consumers want, improve quality, or save costs without causing harm), (d) regulation should be fair, predictable and strictly enforce the laws to ensure high quality standards are met and that low performers improve or be removed from the pool of choices available to consumers.

4. Streamline Regulation of Medical Groups/IPAs

The state entity for regulation of managed care should be given the authority and responsibility to facilitate the existing oversight of medical groups, IPAs and other entities that enter into risk contracts with Knox-Keene regulated health plans, including as priorities solvency and quality audits (as described below) but also considering oversight of other issues such as the credentialing process, monitoring of provider compensation arrangements and their disclosure, dispute resolution processes, and other areas if necessary. This oversight should be exercised in a way that would reduce cost for providers and health plans. For example, the regulatory authority should consider and work together with ongoing streamlining efforts of accreditation and other private organizations.

5. Streamline Solvency Audits

Currently, health plans audit provider organizations to determine whether they are fiscally solvent and capable of assuming risk. This creates burdens for provider organization that might contract with many different plans and difficulties because health plans may seek information that medical groups consider proprietary.

(a) In order to facilitate the development of this information in a manner that is less burdensome, a provider organization should be able to request that the state entity for regulation of managed care oversee one solvency audit on a periodic basis that would meet the requirements of all contracting health plans.

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[6] The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.

(b) The state entity for regulation of managed care may contract, where appropriate, the authority to audit provider organizations by subcontracting with independent, third-party organizations, such as accounting firms, that meet standards the regulatory entity establishes through a competitive process.

(c) The oversight entity should convene a stakeholder-working group, including provider organizations that contract with multiple health plans and the health plans with which they contract to develop acceptable, specific solvency standards and financial documentation. The solvency standards may vary by size and type of organization, amount of risk assumed, or other pertinent factors.

6. Streamline Quality Audits

In order to comply with Knox-Keene standards for health plan quality, health plans must audit the quality of the provider organizations with which they contract.

(a) In order to facilitate the collection of standardized data and quality processes necessary to audit quality in an efficient manner, a provider organization should be able to request that the state entity for regulation of managed care oversee one quality audit of that data on a periodic basis (e.g., annually) that would determine compliance with the quality standards of all contracting health plans. The regulatory authority would need to provide that the audits establish whether provider organizations treat different plan members differently. When standardized data is not available, health plans may use other information to ensure quality of care.

(b) The state entity for regulation of managed care may contract, when appropriate, for audits of medical groups with independent, qualified, third-party organizations that meet standards the state entity for regulation of managed care establishes.

(c) The cost of the single quality audit should be shared among all the health care service plans with which a provider organization contracts. This would save health care service plans and providers time and money.

7. Data Should be Public

The Task Force makes numerous recommendations that encourage state entity(ies) for regulation of managed care and for data collection to work in collaboration with, and not duplicate the efforts of, private sector initiatives and the data collection efforts of private purchasers or accrediting bodies. The Task Force endorses these efforts to the extent the following are satisfied, where the private activity is being conducted to accomplish a public purpose:

(a) There must be full disclosure upon request of all survey processes, methodologies and investigative results—the data collection protocols and results should be publicly available to the same extent they would be if the effort were conducted by the state entity itself.

(b) Private data collection standards, protocols and results of data collected must be available to the public in a timely manner at no or low cost to the extent that data satisfies public

oversight requirements. The cost (if any) to the public should be nominal and reflect only the costs of copying and distribution.

(c) The collaboration with private entities by the state regulatory bodies should not limit or impede the public processes by which the state determines which data should be collected and how quality should be monitored.

(d) The state entity for regulation of managed care or other appropriate agencies should ensure that any privately collected results relied upon by the state to satisfy its requirements are valid.

8. Promote Inter-departmental and Private Sector Coordination and Eliminate Redundancy

Until oversight is consolidated, government departments, in addition to the state's managed care regulatory authority, that regulate health insurers that offer indemnity, PPO, and EPO products (e.g., DOI, US DOL) or oversee health services for different populations (e.g., DHS, Division of Workers' Compensation, US HCFA), should coordinate activities and streamline information sharing. The state entity(ies) for regulation of managed care should also coordinate with private sector quality measurement and accreditation bodies to develop solvency, accounting and quality standards to ensure that they satisfy their respective requirements with regard to the scope of issues covered by the audit.

Government departments should seek to avoid duplication of audits conducted by independent third-party, government-approved auditors. Carriers that are in the business of both indemnity insurance and HMO coverage should not be subjected to duplicative business audits by the Department of Insurance and the new state entity for regulation of managed care. Health insurers offering indemnity, PPO, and EPO products should be subject to regulatory review by other departments only in those areas where the program differs from Knox-Keene Act requirements or exceeds those requirements.

9. Meet the Challenges Presented by Accelerating Industry Change

1. (a) The state entity for regulation of managed care should define and publish formal policies and procedures regarding filing formats, filing requirements, interpretive guidelines for plans and counsel regarding how requirements apply in critical areas, and an approval process that contains quality control and "consistency control" checks. With criteria set up front, health care service plans could plan effectively and modify applications to improve likelihood of approval. Furthermore, with standard decision criteria, the regulatory authority's regulators would become more efficient.

(b) The state entity for regulation of managed care should take steps to improve efficiency and consistency of its decisions. Steps may include the following: (a) upgrading information technology capabilities, (b) expediting the hiring of additional staff provided for by the budget augmentation, (c) setting guidelines for and requiring counsel to participate in training about policies and interpretations, (d) setting standards for health care service plan documents, (e) consistently assigning counsel to the same plans (but with enough rotation to inhibit conflicts of interest), (f) reviewing workload allocations, and (g) educating staff about the health services industry and managed health care.

(c) Legislation should be passed that would allow health care service plans to consolidate minor amendments, as defined by the state entity for regulation of managed care, that occur during the year into one annual filing.

(d) The recent DOC budget augmentation should be evaluated to determine its impact on responsiveness and to assess the need for additional or reallocated funds, given proposed steps for streamlining.

(e) Health care service plans should be allowed to consider new product material modifications approved, if the state entity for regulation of managed care does not "act" as defined by Knox-Keene Act Section 1352(b) by approving, disapproving, suspending or postponing approval within a time frame (e.g., 60, 90, or 180 days) designated in advance by the regulatory entity. As under current law, any such order may not be issued without the approval of the supervising counsel and assistant commissioner. If the state entity for regulation of managed care requires changes to any aspect of the material modification after the designated period, the health care service plan should be required to make those changes prospectively, but should not be subjected to departmental disciplinary actions.